

Maryland HealthChoice Demonstration
Section 1115 Quarterly Report
Demonstration Year 21
Quarter 1 7/1/2017 - 9/30/2017

Introduction

The HealthChoice section 1115(a) demonstration is designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage and targeted benefits to certain individuals who would otherwise be without health insurance or without access to benefits tailored to the beneficiary's specific medical needs. Now in its twenty-first waiver year, Maryland implemented the HealthChoice program and moved its fee-for-service enrollees into a managed care payment system following approval of the waiver by what is now the Centers for Medicare and Medicaid Services (CMS) in 1996. Under the statewide health care reform program, the state enrolls individuals affected by or eligible through the demonstration into a managed care organization (MCO) for comprehensive primary and acute care, or one of the demonstration's authorized health care programs.

The state's goal in implementing and continuing the demonstration is to improve the health status of low-income Marylanders by:

- Improving access to health care for the Maryland population;
- Improving the quality of health services delivered;
- Providing patient-focused, comprehensive, and coordinated care designed to meet health care needs by providing each member a single "medical home" through a primary care provider (PCP);
- Emphasizing health promotion and disease prevention by providing access to immunizations and other wellness services, such as regular prenatal care; and
- Expanding coverage to additional low-income Marylanders with resources generated through managed care efficiencies.

Subsequent to the initial grant, Maryland requested and received several program extensions, in 2002, 2005, 2008, 2011 2013, and 2017. The 2017 extension made the following changes to the demonstration:

- Created a Residential Treatment for Individuals with Substance Use Disorder (SUD) Program as part of a comprehensive SUD strategy;
- Created Community Health Pilot Programs:
 - Evidence-Based Home Visiting (HVS) pilot program for high risk pregnant women and children up to two (s) years of age; and
 - Assistance in Community Services Integration Pilot (ACIS);
- Raised the enrollment cap for the Increased Community Services (ICS) Program from 30 to 100; and
- Expanded dental benefits for former foster youth.

Enrollment Information

Table 1 below provides a comparison of enrollment counts between the previous and current quarters. These counts represent individuals, as opposed to member months.

Table 1. Enrollment Counts

Demonstration Populations	Previous Quarter (as of June 30, 2017)	Current enrollees (as of September 30, 2017)
Parents/Caretaker Relatives <116% FPL and Former Foster Care	213,276	213,812
ACA Expansion Adults	305,431	306,660
Medicaid Children	457,414	456,607
SSI/BD Adults	88,318	88,915
SSI/BD Children	22,615	23,673
Medically-Needy Adults	22,658	22,290
Medically-Needy Children	5,908	5,905
SOBRA Adults	8,807	8,554
MCHP	114,867	113,669
MCHP Premium	30,882	31,723
PEPW	5	0
Family Planning ¹	9,617	9,944
Increased Community Services	28	29
WBCCHP	138	132

Outreach/Innovative Activities**Medicaid and National Diabetes Prevention Program (DPP) Demonstration**

The Medicaid and National DPP demonstration began its second program year during this reporting period. The four original MCOs, Amerigroup, Jai Medical Systems, MedStar Family Choice, and Priority Partners, continued to participate in the demonstration. All were approved for no cost extensions and awarded second year grant extensions. Major objectives for the second program year include continuing to grow enrollment, improving retention, strengthening capacity, provider engagement and exploring and recommending sustainability strategies beyond the grant funding period. As of September 2017, the demonstration reached enrollment of 354 participants, with an additional 41 Medicaid MCO members scheduled to start their first class.

¹ The Department is currently investigating the recent increases in Family Planning enrollment. The Department hypothesizes that these increases could be related to recent federal policy changes regarding employer based health plans.

As part of the Demonstration effort, the Department's public health partners oriented and trained DPP suppliers on standard industry billing procedures and requirements with the intent to prepare for transition from grant-based funding to a service reimbursement model, and in anticipation of the Medicare Expanded Model DPP. The Department continues to inform internal and external stakeholders, both at the national and local level, on the value of DPP through presentations, webinars, and articles.

The Department and MCOs continue to meet routinely to discuss program techniques, lessons learned, as well as to monitor the Medicare DPP rule progress. As follow-up to the annual meeting in Atlanta in June 2017, the Department began planning an in-person meeting, including demonstration MCOs and DPPs, to be held the next quarter. Enrollment into the demonstration is scheduled to conclude January 31, 2018.

Community Health Pilots

As of July 2017, the Department had issued Requests for Applications for eligible government entities to apply for federal matching funds for the two Community Health Pilots included in the §1115 HealthChoice Waiver Renewal application: Evidence-based Home Visiting Services for High Risk Pregnant Women and Children Up to Age 2; and Assistance in Community Integrated Services for high-risk, high-utilizing Medicaid enrollees who are either transitioning to the community from an institution or at high risk of institutional placement. The Department provided technical assistance to stakeholders on the application process and requirements through webinars, a dedicated email account, information sheets posted on the Department's waiver renewal website and conference calls. The Department is in the process of conducting in-person meetings with applicants to clarify any remaining questions regarding program and financial aspects of the applications, including payment rates and terms and conditions of pending awards.

Additionally, Medicaid worked with its Public Health Maternal and Child Health Program partners within the Department to begin discussions with the Health Resources and Services Administration (HRSA) around opportunities for local entities to pair other federal maternal and child health funding in support of the HVS pilots.

Matching federal funds are available to certain local Maryland government entities. Up to \$2.7 million in federal match are available for HVS; when combined with the local non-federal share, HVS pilot expenditures may total up to \$5.4 million annually. There are \$1.2 million in federal matching funds each year for ACIS. When combined with the local non-federal share, ACIS Pilot expenditures may total up to \$2.4 million annually.

The pilots are effective from July 1, 2017 through December 31, 2021 and are scheduled to be funded for four-and-a-half-years of the five-year waiver. The Department anticipates that initial awards will be made for both pilots during the upcoming quarter.

Residential Treatment for Individuals with Substance Use Disorders—Institute of Mental Disease Exclusion (IMD)

As of July 1, 2017, with demonstration authority, the Department provides reimbursement for up to two nonconsecutive 30-day stays in IMDs annually for American Society of Addiction Medicine (ASAM) levels 3.7-WM, 3.7, 3.5, and 3.3.

Operational/Policy Developments/Issues

Market Share

As of September 2017, there were eight MCOs participating in the HealthChoice program; their respective market shares are as follows: Amerigroup (23.9 percent); Jai Medical Systems (2.2 percent); Kaiser Permanente (5.3 percent); Maryland Physicians Care (18.7 percent); MedStar Family Choice (7.5 percent); Priority Partners (25.2 percent); University of Maryland Health Partners (3.7 percent); and United Healthcare (13.5 percent).

Maryland Medicaid Advisory Committee

The Maryland Medicaid Advisory Committee (the MMAC) met in July and September 2017. The Department updated the committee on a variety of items, including:

- Updates to the provider enrollment system;
- Waiver, state plan, and regulation changes;
- Recommendations of the Rural Health Delivery Workgroup, which aimed at developing a plan for meeting the health care needs of five rural counties in eastern Maryland; and
- A demonstration of the new online MCO shopping and selection portal.

Family Planning Program

The HealthChoice waiver allows the Department to provide a limited benefit package of family planning services to eligible women—currently, those women at less than 200 percent of the Federal Poverty Level (FPL). The program covers medical services related to family planning, including office and clinic visits, physical examinations, certain laboratory services, treatments for sexually-transmitted infections, family planning supplies, permanent sterilization and reproductive health counseling, education and referrals. Average monthly enrollment during the quarter was 9,816 women, an increase of 2.1 percent over the demonstration year end. Women who receive pregnancy coverage will continue to be automatically enrolled, if eligible, following the end of their pregnancy-related eligibility.

Table 3. Average Quarterly Family Planning Enrollment

Q1 Enrollment	% Change	Q2 Enrollment	% Change	Q3 Enrollment	% Change	Q4 Enrollment	% Change
9,816	2.1%						

Rare and Expensive Case Management (REM) Program

The table below shows the status of REM program enrollment.

Table 4. Current REM Program Enrollment

FY 2018	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	158	120	50	130	4,318
Quarter 2					

FY 2018	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
<i>Quarter 3</i>					
<i>Quarter 4</i>					

Reasons for disenrollment or discharge from REM include aging out of the REM qualifying diagnosis, loss of HealthChoice eligibility, loss of MA eligibility, death, or a request to return to managed care.

Table 5. REM Complaints

FY18 Q1	Transportation	Dental	DMS/DME	EPSDT	Clinical	Pharmacy	Case Mgt.	REM Intake	Other
REM Case Management Agencies	0	0	0	0	0	0	8	0	0
REM Hotline	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	8	0	0

The following table displays the types and total of significant events reported by the case management agencies during this quarter. Significant events are submitted for various reasons including: families loss of electricity, delays in obtaining needed equipment, Child Protective Services report, unanticipated death of a REM participant, loss of a caregiver, family contacting the Governor's or Secretary's office, threat to contact the media about an issue, loss of Medicaid eligibility, issues with private duty nursing, child getting injured at school. Agencies report this information on a monthly basis.

Table 6. REM Significant Events Reported by Case Managers

FY 2018 Q1	DMS/ DME	Legal	Media	Other	Protective Services	Appeals	Services	Total
REM Enrollees	7	6	0	56	14	11	6	100

ICS Program

The ICS Program does not currently have a registry. All new applicants begin receiving services upon approval of their application.

Maryland continued providing Medicaid State Plan benefits and home- and community-based services to residents aged 18 and over, enabling qualifying individuals to live at home with appropriate supports, as opposed to residing in a nursing facility. Under the terms of the waiver renewal, Maryland will increase enrollment incrementally over the course of the waiver to a maximum of 100 participants. As of the end of this quarter, there were 29 individuals enrolled in the ICS Program.

MCHP and MCHP Premium Status/Update/Projections

Effective June 1, 2008, Maryland moved its separate CHIP program, Maryland Children's Health Program (MCHP) Premium, into the Medicaid expansion CHIP waiver, so that Maryland's entire CHIP program is operated as a Medicaid expansion. As of September 30, 2017, the Premium program had 31,723 enrollees, with MCHP at 113,669 enrollees.

Expenditure Containment Initiatives

The Department, in collaboration with the Hilltop Institute, has worked on several different fronts to contain expenditures. The culmination of the Department and the Hilltop Institute's efforts are detailed below.

HealthChoice Financial Monitoring Report (HFMR)

Preliminary Service Year 2016 HFMR reports (reported as of March 31, 2017) and the supporting Financial Templates were provided by the MCOs in May of the prior quarter. This information was used this quarter for trend analysis and validity testing purposes during the 2018 rate-setting development.

During this quarter, MCOs were requested to prepare 2017 and 2018 financial projections based on all known rate and State budget activities as of August 2017 using provided financial templates. As of September 30, 2017, all MCO projections were received. In September, MCOs were provided with updated HFMR templates and revised instructions in preparation of the MCO's November submissions.

During the next quarter, MCOs will restate their 2016 Date of Service experience as of September 30, 2017. The final 2016 submissions will most likely be the base period for the 2019 HealthChoice rate-setting period. An independent auditing firm will perform an independent review of each MCO's submission. The next MCO submissions will be due by November 20, 2017. Any additional modifications to the current reporting requirements if requested by the Department will likely be implemented during the month of October.

MCO Rates

The rate-setting team performed the following activities in support of the calendar year (CY) 2019 HealthChoice Rates:

- Prepared and provided new instructions and templates for the final service year 2016 HealthChoice MCO financial submissions.
- In conjunction with the Department's actuarial consultant, provided the Department with response to a proposal from the Maryland MCO Association to modify the Code of Maryland Regulations (COMAR) for future HealthChoice interim rate adjustments.

The rate-setting team performed the following activities in support of the CY 2018 HealthChoice rates:

- Co-facilitated sixth 2018 HealthChoice MCO rate-setting meeting held on July 26, 2017. Topics discussed included: Review of 2018 issues, preliminary 2018 MCO risk scores for HIV/AIDS and geographic/demographic rates, final constant cohort analysis, 2015 Hepatitis C HIV/AIDS relative weights, and revised MCO outlier calculation.

- Provided the Department's actuarial consultant with revised (final) CY 2018 member month projections.
- Provided the Department with a draft proposal to create a HealthChoice "drug pool" policy on very high-cost, low-volume drugs to help mitigate the risk to small MCOs.
- Co-facilitated final 2018 HealthChoice MCO rate-setting meeting held on August 25, 2017. Topics discussed included: Review of 2018 rate impact and assumptions used, 2018 FQHC market rate, 2018 incentives, and the Department's actuarial consultant presentation. MCO packets including individual rate impact analysis were distributed following the meeting.
- Assisted the Department in developing 2018 rate presentation to both the Maryland Health and Budget Secretaries, respectively.
- Participated with various MCOs in providing feedback and assistance in preparation for their individual MCO "one-on-one" meetings with the Department.
- Provided the Department MCO plan profiles in preparation for one-on-one meetings to be held in September between individual MCOs and the Department.
- Provided MCOs 2016 risk-adjusted capital (RAC) assignments.
- The Department's actuarial consultant, on behalf of Hilltop, provided the Department with an analysis comparing administrative cost levels observed in the HealthChoice program to comparable programs in six other states where the Department's actuarial consultant participates.
- Participated on August 22 call with the Department and the Department's actuarial consultant to discuss changes to the CY 2018 rate range methodology.
- Attended and participated in eight MCO one-on-one meetings with the Department to review MCO issues and financial projections for CYs 2017 and 2018.
- On behalf of Hilltop, the Department's actuarial consultant provided the Department with the CMS version of the 2018 HealthChoice certification letters.

The rate-setting team performed the following activities in support of the CY 2017 HealthChoice rates:

- Participated on conference call held July 14 with MCOs, the Department, and the Department's actuarial consultant regarding mid-year 2017 HealthChoice rates.
- In conjunction with the Department's actuarial consultant, provided draft responses to issues raised in letter sent to the Secretary from the Maryland MCO Association (MMCOA) regarding the current mid-year rates in preparation for the Secretary's July 21 meeting with the MCOs.
- Provided the Department with plan-level results regarding the impact of the 2017 mid-year rates. Due to re-basing of the childless adult rates, there was significant impact at the plan level.
- Provided the Department with alternative mid-year rate scenarios which maximize paying higher in the range without additional state funds.
- Participated on conference call held July 24 with the Department and the Department's actuarial consultant to review discussion points raised at Secretary's July 21 meeting with the MCOs.
- The Department's actuarial consultant, on behalf of Hilltop, developed year-to-date June 2017 financial templates to be completed by MCOs. The completed templates were used, in accordance with COMAR mid-year regulations, to update their hospital trend analysis. The

restated trends, in conjunction with the other mid-year analysis, indicated an aggregate mid-year adjustment of less than -0.2 percent (results shared with MCOs August 15). Given these result, the initial January 2017 HealthChoice rates will remain in effect for the entire calendar year, and the previous draft mid-year rates provided to MCOs earlier in the month were not implemented.

- Hosted August 16 rate-setting meeting with new Maryland Physicians Care actuaries and management.
- In conjunction with the Department's actuarial consultant, provided the Department with August 14 written responses to the Maryland MCO Association's August 11 letter to the Department regarding the initial 2017 mid-year rates.
- Participated on August 14 call with the Department and the Department's actuarial consultant to assist the Department for the Secretary's call with all MCOs later that same day.
- Provided rate tables to the Department operations for new 2017 HealthChoice mid-year rates reflecting updated plan risk scores effective October 1, 2017.
- Prepared initial 2017 mid-year MCO supplemental payments for service months July through September. Final supplemental calculations for this quarter will be provided in November.

Financial/Budget Neutrality Development/Issues

The Department is in compliance with all reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements sections of the Special Terms and Conditions (STCs). A budget neutrality worksheet is included in Appendix A of this report.

Member Month Reporting

Tables 7 and 8 display the number of member months for the current quarter by eligibility group. The corresponding figure from the last month of the previous quarter is provided for comparison.

Table 7. Member Month Reporting

Eligibility Group	Total for Previous Quarter (ending June 30, 2017)	Current Quarter Month 1 (July 2017)	Current Quarter Month 2 (August 2017)	Current Quarter Month 3 (September 2017)	Total for Quarter Ending September 30, 2017
Parent/Caretaker Relatives <116% FPL and Former Foster Care	641,034	213,121	213,709	213,812	640,642
ACA Expansion Adults	913,562	305,011	306,266	306,660	917,937
Medicaid Children	1,375,571	456,637	457,167	456,607	1,370,411
SSI/BD Adults	265,163	88,264	88,557	88,915	265,736
SSI/BD Children	67,412	22,811	23,095	23,673	69,579
Medically-Needy Adults	67,621	22,643	22,597	22,290	67,530
Medically-Needy Children	17,365	5,948	5,914	5,905	17,767
SOBRA Adults	26,742	9,038	8,362	8,554	25,954
MCHP	343,648	114,189	114,039	113,669	341,897

Eligibility Group	Total for Previous Quarter (ending June 30, 2017)	Current Quarter Month 1 (July 2017)	Current Quarter Month 2 (August 2017)	Current Quarter Month 3 (September 2017)	Total for Quarter Ending September 30, 2017
MCHP Premium	92,492	30,870	31,446	31,723	94,039
PEPW	13	3	0	0	3
Family Planning	28,651	9,449	10,056	9,944	29,449
WBCCTP	422	136	135	132	403

Table 8. Member Month Reporting for New Programs (For Informational Purposes Only)

Demonstration Group	Total for Previous Quarter (ending June 30, 2017)	Current Quarter Month 1 (July 2017)	Current Quarter Month 2 (August 2017)	Current Quarter Month 3 (September 2017)	Total for Quarter Ending September 30, 2017
ICS	82	29	30	29	88
HVS Pilot*	N/A	N/A	N/A	N/A	N/A
ACIS Pilot*	N/A	N/A	N/A	N/A	N/A
IMD Exclusion*	N/A	N/A	N/A	N/A	N/A

** The HVS and ACIS Pilots, as well as the Residential Treatment for Individuals with Substance Use Disorders (IMD Exclusion), were still in the preparatory phase as of the end of the quarter.*

Consumer Issues

The HealthChoice Help Line serves as the front line of the State's mandated central complaint program. The Help Line assists waiver-eligible consumers with eligibility and enrollment questions, and provides general education about managed care. Help Line staff explain to consumers how to work with their MCOs and how to access carved-out services—services not covered by the MCO but covered by Medicaid. When a consumer is experiencing medically-related issues such as difficulty scheduling appointments with a specialist, filling prescriptions or obtaining preauthorization for services, the call is classified as a complaint.

Complaints are referred to the State's Complaint Resolution Unit (CRU), which is staffed with registered nurses. If necessary, the CRU engages a local Ombudsman, who has the ability to meet with the member face-to-face. If the MCO has issued a denial letter to a member, and the member wishes to appeal the decision through the State's Fair Hearing process, the CRU will assist the member with that process.

The HealthChoice Help Line received 56,509 calls during the first quarter of FY 2018, compared with 52,107 in the previous quarter, an increase of 4,402 calls. The increase in call volume can be attributed to the increase in MCO enrollment; and an increase in eligibility and enrollment questions encountered by consumers applying for Medicaid through the Maryland Health Connection.

Table 9. Total Recipient Complaints (excluding billing)

MCO	Amerigroup (ACC)		Jai Medical Systems (JMS)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)		Sub Totals	
1 st Quarter of Fiscal Year 2018	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Pharmacy	67	24%	2	1%	9	3%	71	26%	17	6%	68	25%	34	12%	8	3%	276	30%
PCP	25	27%	3	32	9	10%	16	17%	7	8%	15	16%	12	13%	6	6%	93	10%
Specialist	33	37%	4	20	7	8%	11	12%	11	12%	8	9%	13	15%	2	2%	89	10%
Prenatal	27	25%	0	0%	15	14%	11	10%	9	8%	5	14%	26	24%	7	6%	110	12%
Pharmacy/ CMC	4	21%	0	0%	2	11%	3	16%	2	11%	1	5%	7	37%	0	0%	19	2%
DMS/DME	1	6%	0	0%	1	6%	7	41%	2	12%	3	18%	2	12%	1	6%	17	2%
Lab. /Tests	1	13%	0	0%	0	0%	4	50%	0	0%	1	13%	2	25%	0	0%	8	1%
Pain Management	20	50%	0	0%	1	13%	0	0%	2	25%	0	0%	1	13%	0	0%	8	1%

*Other categories-63

Not including billing complaints, there were 683 recipient complaints in the reporting period, compared to 780 in the previous quarter. The top three member complaint categories were pharmacy (30 percent), prenatal care (12 percent), access to specialists (10 percent), and access to primary care providers (PCPs) (10 percent). These accounted for 62 percent of all member complaints, compared to 44 percent in the previous quarter. There was no significant change in recipient complaints by MCO.

Including billing complaints, there were 916 MCO recipient complaints, of which 121 were from pregnant women. In addition, any woman who self-identifies to the Help Line as pregnant is referred to the Medicaid-funded administrative care coordinator (ACC) in her county of residence. Another 144 pregnant women called the Help Line for general information and were subsequently referred to the ACC.

Table 10. Recipient Complaints under Age 21 (excluding billing)

MCO	ACC		JMS		KP		MPC		MSFC		PP		UHC		UMHP		Sub Totals	
1 st Quarter of Fiscal Year 2018	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Pharmacy	20	36%	0	0%	3	5%	10	18%	3	5%	14	25%	6	11%	0	0%	56	48%
PCP	9	24%	1	3%	4	11%	7	18%	3	8%	8	21%	3	8%	3	8%	38	33%
Specialist	2	13%	0	0%	3	19%	2	13%	1	6%	2	13%	5	31%	1	6%	16	14%
DMS/ DME	0	0%	0	0%	0	0%	1	33%	0	0%	1	33%	1	33%	0	0%	3	3%
Pharmacy/ CMC	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Laboratory /Tests	0	0%	0	0%	0	0%	0	0%	0	0%	1	100%	0	0%	0	0%	1	1%
Vision	0	0%	0	0%	0	0%	0	0%	1	50%	1	50%	0	0%	0	0%	2	2%

Of the 916 complaints, 116 recipients were under age 21 in the first quarter of FY 2018, compared to 116 out of 1,149 complaints in the previous quarter. This accounts for 13 percent and 10 percent in the reporting quarter and the previous quarter respectively. The top three complaint categories for the under-21 population were the same as for adults: pharmacy (48 percent), access to PCPs (33 percent), and access to specialists (14 percent).

Table 11. Total Recipient Billing Complaints

MCO	ACC		JMS		KP		MPC		MSFC		PP		UHC		UMHP		Sub Totals	
1 st Quarter of Fiscal Year 2018	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Specialist	26	30%	1	1%	10	11%	14	16%	15	17%	14	16%	7	8%	1	1%	88	44%
Emergency	7	17%	0	0%	5	12%	11	26%	8	19%	8	19%	3	7%	0	0%	42	21%
PCP	8	32%	0	0%	9	36%	3	12%	1	4%	2	8%	2	8%	0	0%	25	13%
Laboratory/ Test	9	21%	0	0%	0	0%	17	40%	2	5%	10	23%	4	9%	1	2%	43	22%
Pharmacy	0	0%	0	0%	0	0%	0	0%	0	0%	1	100%	0	0%	0	0%	1	1%

The State also investigates recipient billing complaints. There were 199 complaints in the first quarter of FY 2018 (22 percent of total MCO recipient complaints), compared to 310 (27 percent of the total MCO recipient complaints) in the previous quarter.

The top three bill types this quarter were specialists, laboratory/test, and emergency services. During the reporting period, specialists accounted for 44 percent of billing complaints, laboratory/test for 22 percent, and emergency services for 21 percent. Compared to the previous quarter, emergency service billing complaints decreased by 11 percent, while billing issues for specialist and laboratory/test increased both by seven percent.

MCOs are required to respond to all recipient complaints. The CRU works with MCOs on behalf of the consumer to resolve the complaint. Once a plan is in place, the CRU refers the case to the ACC for follow-up to ensure the complaint has been resolved. When trends are identified, an

inquiry is made to the MCO by the HealthChoice Medical Advisor. If potential policy or systems issues or barriers are identified the MCO may be directed to take corrective action.

Legislative Update

The Maryland General Assembly's 2017 session adjourned on April 10, 2017. The 2018 Maryland General Assembly session will begin on January 10, 2018.

Quality Assurance/Monitoring Activity

Quality Assurance Monitoring

The Division of HealthChoice Quality Assurance (DHQA) monitors HealthChoice MCOs quality assurance activities in accordance with COMAR10.09.65.

Systems Performance Review (SPR)

CY 2016 MCO Corrective Action Plans (CAPs) were reviewed and approved by the External Quality Review Organization (EQRO). The final CY 2016 Statewide Executive Summary was posted to the MCO resource site. The CY 2017 Orientation Manual was disseminated to the MCOs at the September Quality Assurance Liaison Committee (QALC) meeting. The EQRO also provided technical assistance to the MCOs regarding CY 2017 standards and the interim review process.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Review

The EQRO completed all reviews and submitted individual MCO reports to the Department for review and comments. The EQRO also completed the validation of EPSDT data.

Value Based Purchasing (VBP)

The EQRO validated the final codes and results for the VBP ambulatory supplemental security income (SSI) adult and child measures. The Department mailed the first CY 2017 VBP awards letters to each MCO.

Consumer Report Card

The CY 2018 Information Reporting Strategy (IRS) and Analytic methodology was approved by the Department.

Performance Improvement Projects (PIP)

The CY 2017 Controlling High Blood Pressure (CBP) and Asthma Medication Ratio (AMR) PIP were review and approved.

Encounter Data Validation (EDV) Review

The EQRO received EDV sample from Hilltop with MCO CY 2016 encounter data.

The Department reviewed the MCOs Appeals, Grievances and Pre-Service Denial Activities and EQRO complete the first annual report to the Department for review and approval.

The EQRO completed the first Network Adequacy report for the Department for review and approval.

Annual Technical Report (ATR)

The next ATR is due to CMS April 30, 2018.

Healthcare Effectiveness Data and Information Set (HEDIS) Performance Review

The National Committee for Quality Assurance (NCQA)-certified HEDIS vendor provided final audit reports to MCOs and the Department in mid-July. The Department provided the finalized HEDIS 2018 Measures List, including official announcement letters, to HEDIS vendor and all HealthChoice MCOs on August 22. The Department will continue to require each MCO to undergo a full HEDIS compliance audit that includes all measures applicable to Medicaid, except where the measures are identified as carved-out of managed care or otherwise exempted from reporting by the Department. HEDIS 2018 specifications were released by NCQA in August. The vendor presented at the September QALC meeting reporting on specification and guideline changes, new audit requirements, the Department required measure set for 2018 and lessons learned from the HEDIS audit. The vendor also provided copies of the Maryland Statewide Analysis Report to the MCO representatives in attendance and the Department. In mid-September, the vendor provided the Statewide Executive Summary Report and the Consolidated Final Audit Report.

HealthChoice Enrollee Satisfaction Survey

The NCQA Satisfaction survey vendor provided the final results for the 2017 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey administration. A total of 4,337 adult and 5,079 child surveys (among the general population) were completed for this project. The overall response rate for the adult survey was 32 percent and 30 percent for the child survey, which reflects a decrease of two percent for the adult survey and one percent for the child survey when compared to the previous year.

Adult HealthChoice members gave their highest satisfaction ratings to their “Specialist and/or Personal Doctor,” which was consistent with what was seen in 2016. Adult HealthChoice members gave slightly lower satisfaction ratings to their “Health Care and/or Health Plan.” For Composite measures, which assess main issues and areas of concern, adult HealthChoice members give their highest ratings to the “How Well Doctors Communicate” and “Customer Service” composites. The lowest ratings given by adult HealthChoice members were evident for the “Health Promotion and Education” composite, which is consistent to what was seen in 2016.

For child HealthChoice members, survey results for the general population show that parents and guardians continued to give high satisfaction ratings for Personal Doctor with regard to their child’s healthcare. For child HealthChoice members, survey results for the children with chronic conditions (CCC) population show that parents and guardians continued to express high satisfaction ratings as well for their child’s Personal Doctor. For Composite measures, which assess main issues and areas of concern, HealthChoice MCOs received the highest ratings among their child members from the general population for “How Well Doctors Communicate.” Somewhat lower proportions of child members from the general population gave HealthChoice MCOs positive ratings for the “Shared Decision-Making” and “Health Promotion and Education” composite measures. The Department anticipates all final survey reports, which will include Quality Compass data, to be printed and distributed to all HealthChoice MCOs and the Department in October.

Provider Satisfaction Survey

The NCQA Satisfaction survey vendor provided the final results for the 2017 Provider Survey. A total of 1,129 completed surveys were collected. The response rate of 19 percent for this survey administration was three percent lower when compared with 2016 results. Key findings from the 2017 survey show that more than three-fourths of the Primary Care Physicians (PCPs) remain satisfied with their specified HealthChoice MCO. A slightly smaller proportion of PCPs surveyed reported being satisfied with all other HealthChoice MCOs with which they participate, which is consistent with 2016 results. Survey results also continue to show that more than eight in ten PCPs would recommend their specified HealthChoice MCO to their patients or to other physicians. A loyalty analysis from the survey shows again shows that about one-third of the overall PCPs are considered “loyal PCPs,” with approximately two-thirds of PCPs defined as “indifferent” and only 2.4 percent of PCPs as “not loyal.” For this survey, a loyal PCP was defined as someone who is both very satisfied with the HealthChoice MCO and willing to recommend that HealthChoice MCO to patients and other physicians. Among composite measures, HealthChoice MCOs received their highest ratings from PCPs for “Overall Satisfaction” and “No-Show HealthChoice Appointments.” Lower ratings were received for “Finance Issues,” “Customer Service/Provider Relations,” “Coordination of Care/Case Management,” and “Utilization Management.” Final reports of the survey are expected to be distributed to all HealthChoice MCOs and the Department. in October.

Demonstration Evaluation

The Department submitted the draft Summative Evaluation on its due date of April 21, 2017. As of the end of the quarter, the Department had not received any comments nor made any additional changes.

During the quarter, the Department finalized the annual evaluation of the HealthChoice program covering CY 2011 through CY 2015. This rapid-cycle assessment provides program updates and reviews the areas of coverage and access, medical homes, quality of care, special topics, and the ACA expansion. See Appendix B for the full report. In addition, the Department has initiated preparation work for the next HealthChoice annual evaluation, which will cover the period from CY 2012 through CY 2016.

Enclosures/Attachments

Appendix A: Maryland Budget Neutrality Report as of March 31, 2017

Appendix B: HealthChoice Evaluation (CY 2011 – CY 2015)

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